access health CT
Connecticut's Health Insurance Marketplace

AH-1500-E00001

APPLICATION FOR EXEMPTION FROM THE INDIVIDUAL RESPONSIBILITY REQUIREMENT

The Patient Protection and Affordable Care Act (ACA) added §5000A to the Internal Revenue Code (IRC) of 1986. Under §5000A, individuals meeting one of the following criteria are exempt from the penalty imposed for failing to maintain minimum essential coverage, and can apply for the exemption through Access Health CT.

A. Religious Conscience	An individual who has an exemption under section 1311(d)(4)(H) of the ACA which certifies that he is or she is a member of a recognized religious sect or division described in section 1402(g)(1) of the IRC of 1986, and is adherent to the teachings of such a religious sect or division. In general, such religious sects/divisions include those that are opposed to acceptance of benefits or private or public health insurance. Such sect or division must have been in existence at all times since 12/31/1950.
B. Membership in a Health Care Sharing Ministry	An individual who is a member of a health care sharing ministry as defined in section 501(c)(3) of the IRC and is exempt from taxation under section 501(a) of the IRC. Members of the health care sharing ministry must share a common set of beliefs and share medical expenses among members; members must retain membership even after they develop a medical condition; the ministry must have been in existence since 12/31/1999; and must conduct an annual audit by an independent certified public accounting firm.
C. Incarcerated Individuals	An individual who is incarcerated, not including those who are pending the disposition of charges.
D. Membership in an Indian Tribe	An individual who is a member of an Indian tribe, including any Alaska native village, that is recognized as eligible for the special programs and services provided by the United States to Indians.
E. Hardship (General)	An individual suffering a hardship with respect to the capability to obtain coverage under a qualified health plan. Hardship includes financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan.
F. Affordability based on Projected Income	Individuals applying for this exemption must first complete the application for health care coverage used to determine eligibility for advance payments of the premium tax credit. This exemption must be applied for during the open enrollment period for purchasing a qualified health plan.

To apply for an exemption, please complete Steps 1 through 4 below.

An individual over age 30 wanting to purchase catastrophic coverage must receive a hardship or affordability exemption. Individuals age 30 and younger do not need an exemption to purchase this type of coverage.

In addition to the categories of exemptions above, there are several other categories of exemptions that individuals can apply for through the IRS. Information for applying for an individual exemption through the IRS can be found at www.irs.gov.

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Step 1 Tell us about yourself

1. Name *(first middle last suffix)*

2. **Home** address (If you do not have a Home address, please provide at least the City and State where you are seeking an exemption from healthcare coverage)		3. Apartment or Suite Number
4. City	5. State	6. ZIP code
7. **Mailing** address (If different from home address)		8. Apartment or Suite Number
9. City	10. State	11. ZIP code
12. Preferred phone number		☐Home ☐Work ☐ Cell
13. Other phone number		☐Home ☐Work ☐ Cell
14. Email address		15. Preferred spoken or written language (if not English)

16. Date of birth *(mm/dd/yyyy)*

If under 21 years old, parent or guardian's name: _____

17. Sex

☐ Male ☐ Female

18. Social Security Number (SSN)

__ __ __ – __ __ – __ __ __ __

19. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, name of the tax filer: _____

Social Security Number of the tax filer: __ __ __ – __ __ – __ __ __ __

20. Have you completed the Access Health CT application for health coverage? ☐ Yes ☐ No

If yes, list your Application ID (located in the upper right corner of your Eligibility Decision for Health Care Coverage notice):

_____

Step 2 Tell us about your exemption requirements

1. What dates are you applying for the individual exemption?

From *(month/year)*: _____ to: *(month/year)*: _____

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Step 2 Tell us about your exemption requirements (continued)

- *See the cover page for the descriptions of the different types of exemptions.*
- *You may apply for more than 1 exemption category. Please include supporting documentation with your application.*

2. Check the exemptions you are applying for:

☐ Religious Conscience

If checked, name of recognized religious organization: _____

☐ Member of a Health Care Sharing Ministry

If checked, name of recognized healthcare sharing ministry: _____

☐ Incarceration

☐ Member of a federally recognized Indian Tribe

If checked, name of federally recognized Indian tribe: _____

☐ Hardship

If checked, please describe in detail and include any supporting documentation. See Appendix B (Page 5) for different types of hardship and the supporting documentation that you will need to submit with this application:

_____

_____

_____

_____

_____

(Attach additional paper if necessary)

☐ Affordability based on Projected Income

To apply for the affordability exemption, you must complete the general Access Health CT application for health care coverage during open enrollment and provide the determination notice as documentation.

Step 3 Read and sign this application

- *Sign this application. The person who filled out step 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Appendix A.*

I am signing this application under penalty of perjury. I have provided true answers to all the questions on this form to the best of my knowledge.

Signature of applicant or authorized representative: **Date *(mm/dd/yyyy):***

Step 4 Mail completed application to:

Access Health CT
PO BOX # 670
Manchester, CT 06045-0670

Please allow 90 days for Access Health CT to respond. If you have not received a response after 90 days, please call Access Health CT at 860-757-6841

For information on how Access Health CT collects and uses your personal information, refer to our Privacy Policy at www.accesshealthct.com

NEED HELP WITH YOUR APPLICATION? Email us at **ExemptionsAndAppeals.AHCT@ct.gov** or call us at **1-860-757-6841**.

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Appendix A

Assistance with completing this application

► *You can choose an authorized representative to assist in completing the application (certified application counselors, in-person assisters, navigators and brokers please see below).*

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Access Health CT at 1-855-805-4325. If you are a legally appointed representative for someone on this application, submit proof with the application.

► *If you have an authorized representative now, or would like to add one, please answer these questions.*

Select the type of representative:

☐ Court Appointed Representative and Power of Attorney

☐ Responsible Adult

1. Name of authorized representative *(first middle last suffix)*:		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
8. Email		
9. Would you like to receive copies of notifications? ☐ Yes ☐ No ***if yes***, preferred language: _____		
10. Organization name		11. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
12.Your signature		13. Date *(mm/dd/yyyy)*

For certified application assisters, counselors, navigators, and brokers only.

► *Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.*

1. Application start date *(mm/dd/yyyy)*	
2. Name *(first middle last suffix)*	
3. Organization name	4. ID number (if applicable)

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Appendix B

Types of Hardship and Documentation Requirements

To help you fill out the hardship explanation in Step 2.

▶ *Use the hardship description to help fill out the hardship explanation of Step 2. Include the supporting documents with your application submission.*

#	Type	Submit this documentation with your application
1	You were homeless.	None.
2	You were evicted in the past 6 months or were facing eviction or foreclosure.	Copy of eviction or foreclosure notice.
3	You received a shut-off notice from a utility company.	Copy of shut-off notice from a utility company.
4	You recently experienced domestic violence.	None.
5	You recently experienced the death of a close family member.	Copy of death certificate, copy of death notice from newspaper, or copy of other official notice of death.
6	You experienced a fire, flood, or other natural human-caused disaster that caused substantial damage to your property.	Copy of police or fire report, insurance claim, or other document from government agency or private entity documenting event.
7	You filed for bankruptcy in the last 6 months.	Copy of bankruptcy filing.
8	You had medical expenses you couldn't pay in the last 24 months.	Copies of medical bills.
9	You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.	Copies of receipts related to care.
10	You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child.	Copy of medical support order AND copies of eligibility notices for Medicaid and CHIP showing that the child has been denied coverage.
11	As a result of an eligibility appeals decision, you're eligible either for: 1) enrollment in a qualified health plan (QHP) through the Marketplace; 2) lower costs on your monthly premiums; or 3) cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace.	Copy of notice of appeals decision.
12	You experienced another hardship in obtaining health insurance.	Please submit supporting documentation.
13	General.	Please submit supporting documentation.

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